



Health Services Spending Account Form

Member Information (Please Print)					
Group #	Certificate #	Member Surname	First Name	Employer, Union, School Name	
Member's Home Address		Apt #	Street # and Name	City	Province
Telephone Number : ()			Work ()		

COMPLETE THIS SECTION IF CLAIMING FOR YOUR DEPENDENTS

Dependent's name (Last, First)	Date of Birth (day/month/year)	Relationship to Plan Member
		Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other <input type="checkbox"/> (describe)
		Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other <input type="checkbox"/> (describe)

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purposes of assessing and paying a benefit if any. I acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to the benefit plan member. I authorize ClaimSecure, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure to exchange necessary information regarding this claim to administer my health benefit plan.

Health Services Spending Account Signature

I wish any portion of my claim not paid by my Extended Health or Dental plan to be reimbursed from my *Health Services Spending Account*.
I hereby certify that the above expenses are considered eligible by Revenue Canada to be payable from a *Health Services Spending Account*

Signature _____

Date _____

EXPENSES-- (Attach original receipts and list below)

Nature of expense	Date incurred (dd/mm/yyyy)	Amount

1. Are any health benefits or services provided under any other group insurance or health plan, Worker's Compensation or government plan?
 Yes No

2 b. Name of other insuring agency or plan _____

Total Claim \$

2 a. If yes, indicate member under other plan:
Name _____

Self Spouse

Policy No. _____ Certificate No. _____

Name _____

Date of Birth

Day	Month	Year		

N.B. For coordination of benefits, children must claim under the plan of the parent with the earlier month and day of birth in the calendar year.